Issues brought forward to DHHS from the DHHS Waiver Advisory Committee Membership				
Issues related to lack of standardization of MCO process		**DATE: April 17, 2012**		
	Issues	**LME if known**	**Action Taken**	**STATUS OF QUESTION Issue Closed Out / Resolved**
1	Applications for MCO enrollment vary significantly in expectations, including insurance requirements, subrogation of worker's comp, requirements for Board members driver's licenses	WH, ECBH, Sandhills	All LME-MCOs have received a standardized LIP, agency, and hosptial application.	*Pending Committee Review*
2	Requests for provider credentialing are redundant and extensive	PBH, ECBH, Sandhills WH	LIPs will be able to utilize CAQH data warehouse to address the redundant information - specific information will be in the April Special Bulletin. DHHS is also talking with CSC (DMA Provider Enrollment Agent) about getting the LME-MCO provider information already enrolled in DMA as a Medicaid provider to assist with the LME-MCO with DMA providers already enrolled with DMA to reduce the redundancy information collection.	*Pending Committee Review*
3	Billing systems are different	All	**NEW:** DHHS is aware issue at this point there are three different IT systems with the eleven LME-MCO also recognizing there is standardized transaction billing format for which all LME-MCOs and providers should be using 5010 HIPAA compliance.	**ISSUE CLOSED OUT.** The State cannot require LME-MCOs to utilize one system. The State requires LMEs and the Providers to be able to utilize a standardized 837 / 835 HIPAA billing claims billing process via electronic means. These requirements make the system standardized and to be able to communication.

4	Fidelity to PBH is the goal. PBH does not have CABHAs. Are other LMEs required to have these?	All	**NEW:** Yes. PBH has CABHA's agencies in their network, which started as Comprehensive Provider Organizations. LME-MCOs starting up are required to bring in provider agencies, CABHAs, into their provider network that are in good standing.	**ISSUE CLOSED OUT.**
5	PBH allows more than 2 90801s as long as they are prior authorized. The state does not. What will MCOs be required to do?	All	**NEW:** The minimum is to following the State Plan and LME-MCO can be less restrictive, say for example to provide more, but cannot be more restrictive that what is required in the State Plan.	**ISSUE CLOSED OUT.**
6	Subrogation of Workers Comp - required by WH, but not others	WH but not others	**NEW:** DHHS may require more clarity to this question. Section 7.6 in the LME-MCO contract with DMA classifies the insurance required of all providers.	*Basic minimum requirement* *Pending Sub-Committee Review*
7	In regards to service authorization request the LME-MCO requests for ICF paperwork that is not needed, i.e. hab plans.	WH but not others	UPDATED FROM THE 3-22 MEETING: LME-MCO may not need the Individual Service Plans, but the LME-MCO authorizes services based upon Medical Necessity and Habilitative needs and is within their right, if needed to make an effective service determination	*Pending Committee Review*

8	**UPDATE/REVISED QUESTION:** Community Guide definition - Is the provider agency required to have a fire wall between community guide and provision of services; PBH requires this of its providers but WH does. Is that allowed?	WH	**UPDATED FROM THE 3-22 Meeting:** HB 916 requires fidelity to PBH model as an LME-MCO. Community Guide is a service definition and the standardized service definition does not get into that level of requirement.	*Pending Committee Review*
9	**NEW FROM COMMITTEE MEETING:** What is the status of the Wake & Durham merger and where does that leave Johnston and Cumberland Counties?	Wake, Durham, Johnson, Cumberland	Durham and Wake are in Merger discussion planning to officially merge July 1, 2012. Johnston and Cumberland will be partners connected by an inter-local agreement with the new merged entity.	**ISSUE CLOSED OUT.**
10	**BELOW ARE NEW QUESTIONS FROM THE 3-22 COMMITTEE MEETING:** When are the rules for CABHAs going forward?	All	NEW: DMA has submitted the CABHA rules….????	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*
11	Reciprocity: Most LMEs have asked if this can be approved. Where are we in this process, and will it likely be approved?	All	Not approved. Due to the risk and due dligence in closing the provider network LMEs are required to review the applications.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*
12	LMEs becoming MCOs are expecting applications back before July 1. What is the status of the standardized application?	All	DMA has issued to the LME-MCOs the standardized application information.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*
13	WH has till not paid ICF providers who had their applications in on time. When they pay, they indicate it will be a paper check. The ability to process claims is present, but not the ability to put locator codes, etc in a timely fashion into their system.	WH	See Special IU 94. The State has worked closely with WHN on all complaints and concerns from providers. To date DMA and DMHDDSAS believe that most provider complaints have been resolved.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*

14	WH has not yet paid some psychiatry practices either. The practices are able to bill, but have not been paid.		To date DMA and DMHDDSAS believe that most psychiatry practices complaints have been resolved. All initial complaints should be vetted with the LME, then if unresolved, DMA and DMHDDSAS are willing to assist and be involved if needed.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*
15	LMEs need to be respectful of time frames needed to process info.	All	A transition from LMEs to LME-MCOs of this kind requires a major amounts of infrastructure development requiring LMEs and providers in meeting certain deadlines. The goal is to assist each other in working together utilmately for the benefit of individual and family members.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*
16	1) Timing of the application due dates and processing will most likely also prove to be an issue. Western Highland applications were due back in July of 2011 for a January 2012 effective date. They were unable to process these applications in time for this effective date even with months of processing time. Smokey Mountain and Sandhills are set to go live 7/1; the Sandhills applications were just posted in January and were due by 3/1. This only leaves 4 months for processing time- Western Highlands couldn't do it in over 5. Smokey Mountain applications were just officially rolled out in Mid February and are due by 4/1- less than 3 months for processing. PBH rolled out new counties and their average time for processing ballooned from 90 to 180. This means that clinicians actively accepting Medicaid clients will stop receiving payments.	ALL	Based upon the lessons learned from PBH expansion, WHN, and ECBH startups, the volume of provider applications in Smoky and SHC, the state is issuing guidance in a Special IU regarding the submission of provider applications 60 - 90 days out prior to an effective start date.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*

17	1) Providers that work in one or multiple agencies also need to be linked to each agency's group with the LME since they do their own billing. So far we've seen that the LMEs have different requirements. Western Highlands allowed ACT to submit the original application, and then any agency a provider worked with could submit a copy of the original application with a note that this provider would also bill through their agency. ECBH did not allow this- they made us turn in two separate and original applications, evaluations, etc for every location the provider needed to be linked to. This is time consuming and repetitive. Ideally, these LMEs should understand that individuals may work in more than one agency/facility, etc and they should have some kind of protocol in place for this. It is fairly standard with insurance companies that if a clinician has already been credentialed and has a number, linking is a one page request. For this purpose, we suggest either allow us to submit copies of the original application, or allow the agency to submit a letter to the LME noting that the credentialing process is already in place for "provider X" and that when credentialing is complete, to please add them to both groups.		The State has required LMEs to have a standardized application process. LMEs starting early were operating in good faith while attempting to stay on schedule. The State has been actively working with the NC Council of Community Programs in effort to find a common solution. There have been a couple of companies with which LMEs can contract to assist in the application credentialing and enrollment process. This issue is still being reviewed.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*
18	We are having issues with payment for Primary Care physicians for psychiatric diagnoses in assisted living facilities (POS 13) and Nursing Facilities (POS 31, 32) using E&M codes. This exception needs to be applied to these places of service. "Other physicians do **NOT** need to enroll with the LME-MCO to bill E&M codes in their offices. For example, MDs could, and should, continue to bill a 99213 for seeing a child with ADHD."	ALL	Specific issues should be submitted to DMA for research.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*
19	We have been feeding info on the service change issues. DWAC input on people losing services. PMPM should the PCP be reduced if PCP responsibilities transferred to providers without compensation. Provicer rate for work should be required. We do not mind doing the work if compensated.	ALL	One of the benefits of the 1915 b/c waiver is that LME-MCOs will have the ability to set rates with providers, who can be fairly compensated based upon the need and demand of services within a LME-MCO provider network.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*

20	Existing CAP-IDD waiver has been extended until 6/28/12 and as far as we know CMS has not yet approved expansion of the Innovations Waiver beyond PBH's original five counties so legally ECBH should not implement their new protocol on April 1 - which by the way, doesn't allow due process. The calls are pouring in from ECBH area as consumers receive notice, we've notified the Secretary and are working up a potential complaint in federal court if necessary.	ALL	CMS has officially approved the NC Innovations waiver backing the approval to October 2011.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*
21	How can any system support risking a 44 percent reduction in services to people in order to expand administrative structure. Dept. DHHS should intervene and select another MCO for that area. So what are they doing, because they doubt they will get this, is that they've met with all providers that get county money to tell us it likely will be cut 45%. For us, that is $250,000.	????????????	More detail needed to respond to this question.	*Pending Committee Review* *Pending staff and committee review*
22	Peggy, I have thought about this. What we relied on is the service definitions. The enhanced service definitions include the plan development and when the person is referred for an enhanced service, the provider would develop the plan and bill for it according to the service definition.	????????	Clarification needed to respond to this question.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*
23	Materials on Care Coordination. Have they provided anything in the meeting?		Would this be a presentation of interest for the DWAC?	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*
24	As follow up to PLLF meeting today where issue of Care Coordination and IU #94 and Special Medicaid Bulletin was discussed. Here is another understanding or interpretation of those two documents on what Care Coordination is supposed to be. Basically not a service available as most services convert to Waiver sites. So we close all TCM positions and funding and then have to pick up the unfunded PCP process without changes in that process. Makes no sense.	ALL	A presentation might be of interest to the DWAC, perhaps with a representative from SMC.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*

25	The part about children really concerns me, if each provider has to maintain the PCP planning process, that is where we had trouble before with agencies holding on to indidivuals because there was no TCM to coordinate care across the system. Appears to me this a blatant attempt to misinterpret both the IU #94 and the Special Medicaid Bulletin. I welcome responses. The initial is "this is how PBH does it". Even with the Community guide on the IDD side at $75/month that is not enough to offset the cost of developing the PCP. Clearly these documents say that is the Care Coordinator's role.		The role of the care coordiantion is to coordinate care. The responsibility for the PCP is outlined in several different documents according to level of service.	*Pending Committee Review* *Pending staff and committee review*
26	Western Highlands CFAC asked: Western Highlands didn't answer. Heard one provider is having financial issues already and going out of business because of processing issues. Please check.		More specific information needed to process.	*Draft Answer* *Pending Sub-Committee Review* *Pending staff and committee review*
27				
28				